Application for Health Coverage

State of Tennessee • Department of Finance and Administration

Return applications to:
801 Pine Street, Chattanooga TN 37402
AccessTN is administered by BlueCross BlueShield of Tennessee, Inc. - an Independent Licensee of the BlueCross BlueShield Association

See www.AccessTN.gov or call 1-866-636-0080 toll-free for help with questions or with this application. **Complete all sections in blue or black ink or type and sign. All signatures must be original. Faxed applications will not be accepted.** You should make a copy of this application and all supporting papers before sending. AccessTN will not return copies. We may request additional information.

Section A - Your Applicant Information

Last Name	First Name	MI	Gender ❑ Female ❑ Male	Date of Birth (mm/dd/yy)	Social Security Number

Birth name, if different	Place of Birth (city or county & state)

Home Address (proof required as shown page 10)	City	State	Zip Code

How long have you lived at this address? _____ If less than six months, list prior address

Mailing Address (if different from home address)	City	State	Zip Code

Home Phone, with area code ( )	Work Phone, with area code ( )	What is the best way to contact you? (e.g. if cell phone or email - provide address or number)

State of most recent Drivers License and # | Status: ❑ current ❑ expired ❑ other _____

TN resident for at least six months? ❑ Yes ❑ No	US Citizen ❑ Yes ❑ No Qualified Legal Alien ❑ Yes ❑ No	Primary language (optional) ❑ English ❑ Spanish ❑ Other _____

Marital Status	Racial/ Ethnic Heritage (for Title VI purposes)
❑ Married ❑ Single ❑ Divorced ❑ Widowed	❑ Asian ❑ Black/African American ❑ Hispanic/Latino ❑ Native American/Alaska Native ❑ Native Hawaiian/Pacific Islander ❑ White/Caucasian ❑ Mixed Ethnicity/Other _____

Number of people living in your household?	Total family income: (can be approximate)		
	❑ $0 - $15,000	❑ $15,001 - $30,000	❑ $30,001 - $45,000
	❑ $45,000 - $60,000	❑ $60,001 - $75,000	❑ over $75,000

This is for program information and will not affect your eligibility.

Have you ever been on TennCare? ❑ Yes ❑ No	If yes, did your TennCare end after July 2005? ❑ Yes ❑ No	If yes, when? (mm/dd/yy)

❑ Check here if you are applying for help paying your premiums. Persons with family income of $60,000 or less a year may qualify, if funds are available. To qualify, you must include the separate Premium Assistance Application.

Section B - Health plan

Choose your benefit plan- see detail in our "AccessTN Additional Information" booklet or online AccessTN.gov

❑ $1,000 deductible – Plan 1000

Premium assistance is available for Plan 1000 only.

❑ $2,500 deductible – Plan 2500

This plan qualifies for a health savings account.

❑ $5,000 deductible – Plan 5000

All coverage begins on the first day of the month.

Section C - Required Premium Information

Height	Weight

Have you used tobacco products during the past 12 months? ❑ Yes ❑ No

You will be billed if approved. You can estimate your premium using the premium tables in the AccessTN application information booklet.

Section D – Check the way you are showing you are uninsurable (choose only 1)

Choose one of the boxes below, to tell how you are showing that you are uninsurable:

❑	1.	**Two Insurance Company Denials of Coverage Due to Health Reasons**

Since July 2005, were you denied individual health insurance coverage by **two** (2) different companies due to any health reason? If yes, you must attach copies of insurance denial letters. A letter from an insurance agent is not sufficient; it must be an official letter from the insurance company. A list of the insurers is located at www.AccessTN.gov.

❑	2.	**Medical Underwriting by AccessTN** (requires a fee to be paid with this application, except, for a limited time, AccessTN will pay this fee for applicants who were disenrolled from TennCare.)

If you mark this box, we will review your health history to see if you qualify for coverage. Qualification in this way can be based upon any health condition. This is called medical underwriting and requires a **cashier's check or money order for $75.00, unless you are a TennCare disenrollee. It should be made payable to Fort Dearborn Life Insurance Company**. **This fee is non-refundable** if your health history is sent for underwriting **regardless** of the outcome of underwriting. If you choose this method to qualify, you may also be responsible for getting additional doctor's records, as requested.

❑	3.	**You have one of Our Listed Medical Conditions, with Physician's Statement or Letter**

This way is based upon **specific health conditions**. Within the last three years, have you had any diagnosis, treatment, or medical advice relating to any of the medical conditions listed on the **Attending Physician's Statement**? If yes, you must attach the statement from your doctor including the diagnosis and billing code for the condition. A form is enclosed for your doctor's use or one can be found online at www.AccessTN.gov. Or your doctor can write us a letter with the required detail. The statement should be attached to your application. If your medical condition is not one of the 55 conditions on the list (subject to change), you can still use method 1 or 2 above to show that you are uninsurable.

Section E - Pick the eligibility category you are applying for

Check either box 1 or 2 below to pick your eligibility category (pick only one)

❑	1.	**Regular AccessTN –** this category has lower rates and a pre-existing conditions waiting period*. **Note: former TennCare enrollees may qualify for either this category or for TennCare Portability.**

To be eligible to participate in regular AccessTN you must:

- Not have access to other health insurance when you apply (like group or major medical insurance - see information on page 3 about what counts as other health insurance)
- Not have had health insurance within the last six months
- Have used up any continuation coverage (COBRA) if you had group health insurance terminated

*See plan materials or www.AccessTN.gov for more detail about terms of pre-existing conditions period.
As of the printing of this paper, the pre-existing waiting period is six months, subject to change by AccessTN.

❑	2.	**TennCare Portability –** this category has higher rates and no pre-existing conditions waiting period**.** **Note: former TennCare enrollees may qualify for either this category or for Regular AccessTN above.**

To be eligible for TennCare Portability, you do not have to go without insurance for 6 months. You must have been on a HIPAA or guaranteed issue policy since you were disenrolled from TennCare or have been disenrolled within 63 days.

For Box 2 you must answer these 3 questions	❑ Yes	❑ No	Were you in an eligibility category disenrolled from TennCare during or after August 2005?
	❑ Yes	❑ No	Since TennCare, have you been on a HIPAA policy or guaranteed issue policy? (if yes, please list insurance company- _____);
	❑ Yes	❑ No	Has there been any break in coverage since TennCare of 63 days or more?

Section F - Other Insurance Coverage

Have you ever been covered by TennCare? ❑ Yes ❑ No If yes, when?

Are you eligible for Medicare? ❑ Yes ❑ No

Are you employed? ❑ Yes ❑ No If no, when were you last employed?

If yes, how are you employed? ❑ Full-time ❑ Contract worker ❑ Temporary ❑ Part-time

Please complete the following for your current or most recent employer (if self-employed, say that)

Name of Employer	Street Address	City	State	Zip Code

Does this employer offer group health insurance? ❑ Yes ❑ No

If yes, are you now or have you ever been covered by this employer's health insurance? ❑ Yes ❑ No

If this employer has a group health plan and you are not covered, please tell why: _____

Are you married? ❑ Yes ❑ No

If no, skip rest of this block. If you are married and your spouse is employed, please complete the following:

Does your spouse's employer offer group health insurance? ❑ Yes ❑ No

If yes, are you now or have you ever been covered by your spouse's health insurance? ❑ Yes ❑ No

If spouse's employer has a group health plan and you are not covered, please tell why: _____

Have you been covered by any other insurance (including Medicare or TennCare) in the last 6 months?

❑ Yes ❑ No If yes, tell us below as much as you know about the coverage.

Note: You can qualify for AccessTN even if you have certain other kinds of coverage, including:

- long-term care policies • nursing home coverage • cancer or disease-specific coverage
- accident or disability coverage or liability insurance, including medical payments in an auto policy
- "fixed indemnity"- the type of insurance that pays you a set dollar amount if certain events happen, like a plan that pays you $250 for each day you spend in the hospital.

Just tell us below what you can about your other coverage so we can see what type it is.

Primary Policy Holder		SSN or ID # of Policyholder
Name of Insurance Company	Policy #	Group #

Beginning Date of Coverage	Ending Date of Coverage	Reason Coverage Ended

Type of Policy: ❑ Group ❑ Individual or Family ❑ Do not know ❑ Other: _____	If a Group Policy, provide name of employer

Section G - Protected Health Information and Authorization

Protected Health Information (PHI) means facts and records about your health. PHI may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). It also includes facts like your address and date of birth. Federal and state laws protect the privacy of your health facts. Except as allowed by state and federal law, including for your medical treatment and AccessTN operations, privacy rules say AccessTN or your health providers can't give others information about you unless you give permission**.**

By signing this paper at Section J, you are giving your authorization for your providers or employers or others you name in this application to provide AccessTN information about you as part of your health plan enrollment or coverage. This includes TennCare if you were ever enrolled in TennCare.

Your signature on this application at Section J authorizes disclosure to and use by AccessTN, its contractors, or agents, of information on your health insurance coverage, health insurance applications, medical claims, TennCare or other Medicaid eligibility, and medical record information about you for any lawful purpose, including use by AccessTN to:

a) determine eligibility for coverage;
b) preauthorize or process claims for benefits;
c) perform case management, including utilization or quality assurance reviews; or
d) conduct an audit or investigate allegations of fraud.

Your signature at Section J authorizes any physician, health-care provider, hospital, health plan, insurance company, reinsurance company, or any insurance information bureau to disclose my health information to AccessTN, its contractors, agents, or representatives. This authorization includes the disclosure to and use by AccessTN of the following information, if any:

a) records of alcohol or chemical dependency and my treatment for those conditions;
b) records of any mental health treatment, excluding psychotherapy notes;
c) records of my treatment for AIDS/HIV;
d) records of genetic testing regarding any medical condition listed on this application IF I am using that genetic condition as a basis for medical eligibility or for care management of that condition.

AccessTN contractors include Fort Dearborn Life Insurance Company, Health Assist Tennessee, and Patient Services Inc., and may include others.

Your authorization takes effect on the date you sign this application and remains in effect for twelve (12) months thereafter, and if you are enrolled in AccessTN, for the duration of your AccessTN coverage, plus twelve (12) months, or for the duration of any medical claim, whichever is longer. A photocopy of this authorization is as valid as the original. You understand you may request a copy of your authorization pages. You may cancel this authorization at any time by sending a written request to AccessTN. Your cancellation of this authorization will not affect any action AccessTN took before it received your request, and will not affect its use of your PHI for AccessTN health care operations. If you do not revoke this authorization, it will automatically expire twelve (12) months after termination of your coverage with AccessTN unless you have a claim pending as above.

Federal law requires AccessTN to tell you that when you or state and federal laws permit AccessTN to disclose your personal information to anyone other than another health plan or medical provider, then privacy rules may no longer protect it. Except that alcohol and drug abuse records are protected against re-disclosure by special federal confidentiality rules (42 CFR, Part 2). Those regulations prohibit re-disclosure of alcohol and drug abuse record information without specific written authorization.

Section H - Health History

Please answer the following questions to the best of your knowledge. This will help AccessTN plan for your health care. (A five year time period is used to help identify more of your needs for care management.) This health questionnaire can be updated after the application is sent by mailing any changes to **AccessTN, c/o BCBST, 801 Pine Street, Chattanooga TN 37402**. Also, if you request that we evaluate your insurability, we will use this health history for medical underwriting. But we need your health history either way.

Please be sure to complete all questions. Incomplete applications may be returned.

Applicant Name	Date of Birth	Height	Weight
Have you used tobacco products during the past 12 months? ❑ Yes ❑ No ❑ Cigarettes ❑ Chewing tobacco ❑ Pipe ❑ Cigars		How Long?	How Often?
Have you gained or lost more than ten pounds in the last year? ❑ Yes ❑ No If yes, ❑ Gained weight ❑ Lost weight		If yes, how much?	
If yes, tell the cause of the weight gain/loss if you know:			

Within the past five years, have you been counseled, or consulted a medical provider or received treatment for any of the following? If you answer "yes" to any of the questions below, please list any facts that you remember, such as your doctor's name or date of treatment in the space provided.

1. Heart disease or disorder?	❑ Yes ❑ No
2. Ulcers, stomach or digestive system disorder?	❑ Yes ❑ No
3. Urinary or kidney disorder, or gynecological problem?	❑ Yes ❑ No
4. Diabetes, connective tissue, pituitary, thyroid or endocrine system disorder?	❑ Yes ❑ No
5. Allergies, asthma, or other respiratory system issue?	❑ Yes ❑ No
6. Arthritis, fibromyalgia, back/neck, joint/bone disorder or other musculoskeletal issue?	❑ Yes ❑ No
7. Brain disorder, aneurysm, paralysis, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis, or other nervous system issue?	❑ Yes ❑ No
8. Cancer, tumor, or abnormal growth?	❑ Yes ❑ No
9. Eye or ear disorder?	❑ Yes ❑ No
10. Depression, psychological disorder, or mental illness?	❑ Yes ❑ No
11. Organ or other type of transplant or implant (including breast implants)?	❑ Yes ❑ No
12. Any other injury, surgery, illness or treatment for any condition not already listed; or been recommended to have a test or surgery which was not performed for any reason?	❑ Yes ❑ No

Section H - Health History (continued)

In the past five years, have you been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; used illegal drugs; or been advised by a health care professional to reduce the use of alcohol or illegal drugs? If yes, please explain:_____ _____	❑ Yes ❑ No
In the past five years, have you sustained an injury as a result of an auto or work-related accident? If yes, please explain:_____ _____	❑ Yes ❑ No
In the past five years, have you been treated or diagnosed by a medical professional as having AIDS or AIDS Related Complex (ARC)? We are NOT seeking HIV test results.	❑ Yes ❑ No
Are you currently pregnant? If Yes, please indicate your due date:	❑ Yes ❑ No
This is extra space if you need to write more on any question, or for other information:	

If you are taking medication or were prescribed any medication during the past five years, please list it below. Tell us what you can in the space below about when you took it (for example, "three years ago" or "taking now"), what dosage, and what medical condition is being treated by each medication.

Attach additional pages as needed. You may use a copy of this form or a blank page; however, **you must print your name, sign and date any pages used in addition to this application**.

Name of drug	Condition drug prescribed for (Asthma, etc.)	Dosage & frequency of medication (e.g. 20 mg. twice a day)	Date(s) medication taken (e.g. 2003-August 2005)	Name and address of prescribing provider

Section I - Statement of Understanding and Affirmation

By your signature at Section J, you are expressly affirming the following statements:

I am applying to AccessTennessee (AccessTN) a non-profit entity of the State of Tennessee, for an individual policy of medical, surgical, prescription and hospital insurance. I understand that this health plan will be partially supported by the State of Tennessee and possibly in the future by federal funding. I understand that I do not have to sign this form. However, I understand if I do not complete and sign this form, or if I take back my permission in Section G, AccessTN may deny my eligibility. Incomplete or unsigned forms may be returned. If I submit an Optional Application for State Premium Assistance, it is incorporated by reference in its entirety as an attachment to this application, as are any attached documents. I affirm by my signature below that I have read and understand these provisions, and that my answers on this application are complete and correct to the best of my knowledge. I understand that benefits, premium assistance, and care management guidelines are subject to change for all AccessTN plans by its board of directors (Board).

- I AFFIRM THAT THE INFORMATION PROVIDED ON THIS APPLICATION IS CORRECT UPON PENALTY OF CRIMINAL OR CIVIL PROSECUTION. I understand there are penalties for not providing correct information, for allowing someone else to use my benefits, and for other acts of fraud. I understand my duty to inform AccessTN timely about changes in my work, income, or access to other insurance. I understand computer cross-checking with other state or federal agencies may be used to verify my information, and I will cooperate with requests for additional information.
- I affirm that my employer(s) has not paid and will not pay or reimburse my premiums for AccessTN. I understand that no one except my family or personal friends can assist with payment of my premiums, except according to guidelines set by the Board and which may be changed from time to time. I understand that, apart from premium assistance, there are currently NO restrictions on assistance I may receive from any source for my AccessTN deductibles, coinsurance, and copayments, subject to change by the Board. However, I will disclose any assistance with my AccessTN premiums I receive from any other person or organization, including my medical providers. I know I can check www.AccessTN.gov or call AccessTN at 1-866-636-0080 to get the most current guidelines and member materials.
- If this application contains material misstatements or omissions, I understand that AccessTN may do any or all of the following within two years from the date the policy was issued:

  a) cancel the agreement as though it was never effective and refund premiums, less any claims paid;
  b) deny benefits under the pre-existing conditions period and recover claims paid; or
  c) take any other action available to it by law.

  This time limit does not apply to fraudulent misstatements. My application is part of any policy issued by AccessTN. I understand the State Office of Inspector General (OIG) investigates for fraud in AccessTN. This provision also applies to my on-going duty to timely inform AccessTN about changes in my eligibility for benefits or premium assistance, and I will cooperate with any investigation conducted on behalf of AccessTN.
- I understand that a pre-existing condition includes any condition which, during a period immediately preceding the effective date of my coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care, or treatment was recommended or received as to such condition. I understand the most current information about the pre-existing conditions waiting period is available at www.AccessTN.gov or 1-866-636-0080 toll free.
- I understand and agree, if I am granted AccessTN coverage, that, as approved by its Board and as permitted by law, AccessTN may vary deductibles, coinsurance, or treatment levels of its health plans for medical conditions according to criteria which it may establish, by severity of condition, by enrollee category or enrollee income level, or by other reasonable criteria. I understand and agree that AccessTN may vary benefit level according to clinical criteria, by level of enrollee compliance with AccessTN care management, health incentives, or by other Plan guidelines. I agree to cooperate with and adhere to AccessTN health promotion and disease prevention, including specifically AccessTN care management guidelines as periodically established by the Board. I agree that if I fail to comply with AccessTN care management guidelines, my AccessTN coverage may be affected, including but not limited to reduction or elimination of any incentive discount or premium assistance I may be receiving, and including reduction of my insurance coverage. I agree that for this and all purposes related to my coverage, written notice mailed to my most recent address of record with AccessTN counts as notice to me, according to guidelines established by the Board.

Section I - Statement of Understanding and Affirmation (continued)

- I understand that my coverage will become effective on the first day of the month, based on the notice of the Plan Administrator that I have been approved. I understand that no coverage will be in effect until my application has been approved by AccessTN and the full correct initial premium is paid and processed, according to AccessTN policies and procedures. If I am not approved for coverage or if I do not pay my premium, AccessTN shall have no obligation to insure me.
- For each successive month of coverage, I understand that my premium must be received by the Plan Administrator on or before the due date. If I arrange for automatic payment by bank draft or by credit or debit charge, such transaction will be made according to the schedule provided by the Plan Administrator, and may be before the due date. I shall have a grace period of thirty-one (31) days from the due date, inclusive. However, I understand that my benefit eligibility may be suspended beginning the 1st of any month if the Plan Administrator has not received and credited collected funds to my AccessTN account by the due date, and shall remain suspended during my grace period until such funds are received and processed. I understand that my coverage will be terminated at the end of the thirty-one (31) day grace period if my payment has not been received, or if my check or other payment is disallowed by my financial institution without such payment funds being collected by the Plan Administrator. Any payments or termination, including a waiting period to reapply for coverage, shall be subject to the policies of AccessTN. I understand that my 31 day grace period does not begin on the date I receive notice, but shall begin according to the above schedule as set by AccessTN.
- AccessTN will not discriminate against any individual or group because of race, sex, religion, color, national or ethnic origin, age, disability, or military service. Applicants and AccessTN participants may file written complaints regarding discrimination by writing to AccessTN, Division of Insurance Administration, WRS Tennessee Tower, 26th Floor, 312 8th Avenue North, Nashville, TN 37243-0295.
- AccessTN has procedures under which applicants and members may have grievances reviewed. Applicants may file complaints and grievances related to the AccessTN application procedure by writing to AccessTN, at the above address.

Section J – Application Signature

Your signature applies to the entire application and to any attachments. It expressly applies to Section G "Protected Health Information" and to Section I "Statement of Understanding and Affirmation".

("Attachments" above specifically includes Optional Application for State Premium Assistance, if any)

Printed name of applicant	Social Security Number
Signature (in ink) of applicant (or legal guardian if applicant is legally incompetent)	Date
If signed by a legal guardian or conservator of the applicant, please print name & address. We may ask for legal documentation.	

Section K - Persons, if any, who helped you fill out this application

The applicant is responsible for information in this form and must sign above that all information is true and correct to the best of his or her knowledge. Applicant should also provide the information below if a friend, family member or advocate helped fill out this application. Legal guardian or conservator information is not required by this section.

Name	Organization, if applicable, or Relationship		Phone
Address	City	State	Zip Code

Applicant should sign below ONLY if she or he gives AccessTN permission to communicate about the applicant's information directly with:

❑ the person or organization named above as assisting with this application, and / or

❑ the following persons (listing their relationship) _____

Applicant's Signature: Date: